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PUBLIC ASSESSMENT OF EXPIRING PUBLIC HEALTH SERVICE ACT AUTHORITIES

BACKGROUND REPORT

PREPARED FOR THE USE OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
HOUSE OF REPRESENTATIVES

AND ITS

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
NINETY-SIXTH CONGRESS

FIRST SESSION

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LETTER OF TRANSMITTAL

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Committee on Interstate and Foreign Commerce,
Washington, D.C., March 21, 1979.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
U.S. House of Representatives,
Washington, D.C.

DEAR MR. CHAIRMAN: I am transmitting a background report on Program Assessments of Expiring Public Health Service Act Authorities. This background report is intended to provide a brief overview of the programs and the manner in which they have worked since their inception. I believe this background report will be invaluable to Members of the Committee as we consider the re-enactment of these legislative authorities. I would like to point out to you that the Congressional Research Service (CRS) provided these on short notice and are not intended to serve as a comprehensive evaluation of these programs. We intend to carry out in conjunction with CRS, more extensive program evaluations in the course of this Congress.

I would like to thank the Honorable Gilbert Gude, Director of Congressional Research Service, and the Education and Public Welfare Division of CRS for their assistance to us in the preparation of this report.

Sincerely,

HENRY A. WAXMAN,
Chairman.

Enclosure.

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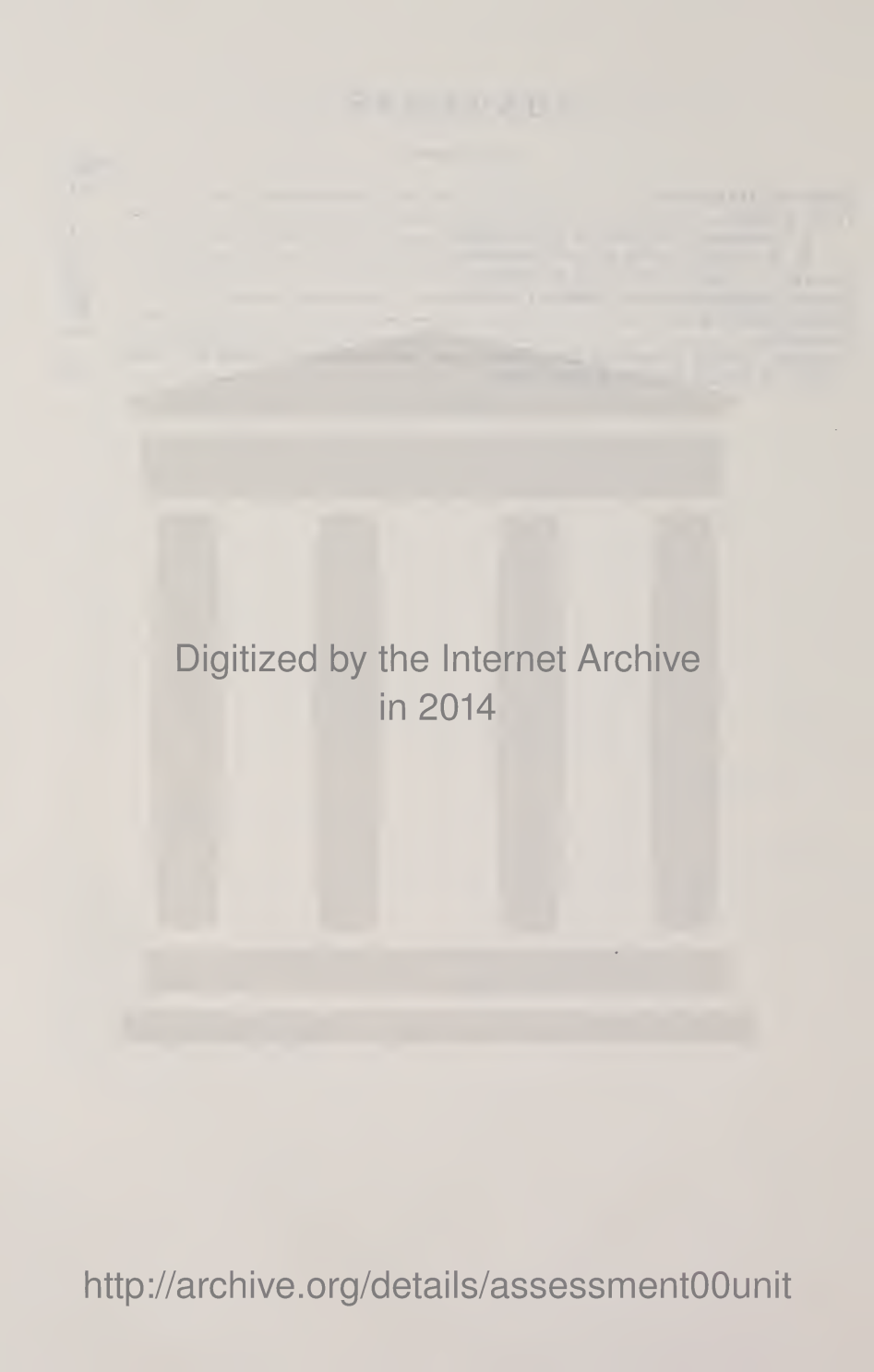

PUBLIC ASSESSMENT OF EXPIRING PUBLIC HEALTH SERVICE ACT AUTHORITIES

DRUG ABUSE

A. National Institute on Drug Abuse

I. Program Description

The National Institute on Drug Abuse (NIDA) administers a number of programs designed to prevent abuse of dangerous drugs and to reduce drug dependency. In addition to the traditional research efforts of a health institute, these programs encompass the funding of prevention and treatment services, training for the delivery of such services, provision of technical assistance to appropriate State and local agencies, and the award of training fellowships for research in areas related to drug abuse. Although some of these activities are authorized by the general provisions of the Public Health Service Act, notably in the research and program support areas, for the most part they are mandated by the Drug Abuse Office and Treatment Act of 1972 (DAOT Act), as amended. DAOT Act, which established NIDA as a separate entity, provides for formula grants to States for various kinds of drug abuse prevention and treatment efforts (sec. 409) and also provides for a program of project grants and contracts for such purposes (sec. 410), continuing earlier programs authorized by the Community Mental Health Centers Act and the Narcotic Addict Rehabilitation Act. Other specific appropriation authorizations for NIDA (HEW) under the DAOT Act relate to the establishment and maintenance of a National Drug Abuse Training Center (sec. 412) and to the conduct of certain designated research efforts (sec. 503).

II. Program Data

	FY 1977	FY 1978	FY 1979 est
Research			
Grants	296	315	351
Contracts	65	44	53
Clinical Training			
Grants	32	26	30
Contracts	64	70	63
Research Training			
Grants	4	6	6
Fellowships	32	33	17
Community Programs			
A. Project Grants and Contracts:			
1. Treatment	181	177	155
2. Demonstration	74	62	42
3. Prevention	25	64	48
B. Formula Grants	55	55	55

SOURCE: NIDA appropriations justifications for FY 1980 and the NIDA budget office.

III. Budget History

AUTHORIZATIONS/APPROPRIATIONS
(millions of dollars)

	FY 1969 1/ Auth./Approp.		FY 1973 Auth./Approp.		FY 1977 Auth./Approp.		FY 1978 Auth./Approp.		FY 1979 Auth./Approp.		FY 1980 (Request)
RESEARCH (Sec. 301, PHS Act)	Indef.	$14.2	Indef.	$ 29.6	Indef. 4/	$ 34.0	Indef. 4/	$ 34.1	Indef. 4/	$ 42.6	$ 50.3
TRAINING (Sec. 301, 303, and 472, PHS Act)	Indef.	.3	Indef. 3/	10.8	Indef.	10.0	Indef.	10.0	Indef.	10.0	8.7
COMMUNITY PROGRAMS											
Project grants and contracts (Sec. 410, DAOTA)	Indef. 2/	[10.2]	Indef. 2/	114.7	160.0	160.0	160.0	161.0	--	161.0	161.0
Formula grants (Sec. 409, DAOTA)	—	--	30.0	15.0	45.0	40.0	45.0	40.0	--	40.0	--
PROGRAM SUPPORT (PHS Act, Sec. 301)	Indef.	2.3	Indef.	11.3	Indef.	16.7	Indef.	16.7	Indef.	18.5	18.6
TOTALS:		27.0		181.4		260.7		262.0		272.1	238.6

1/ Data in this column relate to activities of the National Institute of Mental Health under legislative authority subsequently replaced by the Drug Abuse Office and Treatment Act.

2/ Some funding was based on indefinite authorizations under the Community Mental Health Centers Act and the Narcotic Addict Rehabilitation Act. The DAOT Act authorization for FY 1973 was $65 million under sec. 410; under the CMHC Act, a total of $120 million was authorized for the same year.

3/ There were specific authorizations for the National Drug Abuse Training Center for FY 1972 through FY 1975; the 1973 authorization was $3 million.

4/ The '76 amendments to DAOTA authorized specific amounts for research on designated subjects: $7 million for both FY 1977 and 1978. The '78 amendments authorized the same amount for FY 1979.

Source of Appropriations Data: NIDA appropriations justifications and the NIDA budget office.

IV. Administration Proposal

The presidential budget is based on the assumption that Congress will accept proposed legislation to consolidate the alcoholism and drug abuse formula grant programs under existing law (sec. 301 of the Alcoholism Act and sec. 409 of DAOTA), along with the mental health portion of the comprehensive health planning grants to States funded by the Health Services Administration (under sec. 314(d), PHS Act). As outlined in the Budget Appendix (p. 491), the new program would provide a total authorization of $99 million for FY 1980. This figure was arrived at by adding the FY 1979 obligations for the alcoholism and drug abuse programs ($56.8 million and $40 million, respectively) to $13.5 million for mental health planning, the total being decreased by 10 percent. The principle behind the proposal is the provision of greater flexibility to the States in the allocation of resources.

V. Program Assessment

General

In its detailed and comprehensive report on the national drug abuse problem, issued in 1973, the Shafer Commission (National Commission on Marihuana and Drug Abuse) was highly critical of Federal drug abuse efforts generally and of treatment support activities particularly. Coining the phrase "drug abuse industrial complex" to describe the build-up of grant and contract programs during the previous five years, the Commission characterized the governmental response as "reflexive", duplicative, uncontrolled, and exploited by professional service program administrators. Moreover, it was found that the drug abuse efforts had suffered the same fate as other Government initiatives involving financial support. The problem was being perpetuated and inflated:

> Emergence of a drug abuse industrial complex ensured perpetuation of the crisis psychology surrounding the drug problem. Since public funding is in large measure a function of public concern, agencies and programs had reason to maintain the country's anxiety about drugs. For example, to obtain funds, a locality must show it has a drug problem; chances of funding improve if the problem appears to be growing. Once the money is granted, staffs are hired and the program goes into operation, there develops an institutional reluctance to see the problem get smaller, for so too will the volume of federal or state funds.
>
> The funding mechanism is so structured that it responds only when "bodies" can be produced or counted. Such a structure penalizes a reduction in the body count, while it rewards any increase in incidence figures and arrest statistics with more money. Those receiving funds thus have a vested interest in increasing or maintaining those figures. The statistics, in turn, fuel public and bureaucratic concern, and assure that the problem continues to be defined incorrectly. There is no incentive for local communities to maintain a cautious, unemotional approach to drug use.
>
> In short, the professed goal of social policy is to reduce or eliminate drug use, but the government's response produces financial incentives to magnify the problem. The system seems to reward failure or *status quo* rather than success; it guarantees a continuing sense of crisis.

1/ U.S. National Commission on Marihuana and Drug Abuse. Drug use in America: problem in perspective. Second report of the Commission. Washington, U.S. Govt. Print. Off., March 1973. p. 282.

The Shafer Commission undoubtedly played a role in the evolution of the bill that was enacted as the Drug Abuse Office and Treatment Act of 1972. Four Members of Congress highly influential in the development of that legislation were serving on the Commission at the time it was being considered. A principal aim of the act was coordination of treatment and prevention efforts. The provisions giving statutory basis and specific authority to the Special Action Office for Drug Abuse Prevention (SAODAP), and establishing a "Strategy Council" to fashion a national drug abuse "strategy", were measures aimed at meeting some of the Shafer Commission's criticism.

Although such agencies as the Office of Economic Opportunity and the Law Enforcement Assistance Administration were funding drug abuse projects at the time the Shafer report was written, the principal assistance programs were those being administered by the Division of Narcotics and Drug Abuse in the National Institute of Mental Health, predecessor to NIDA.

While there may be those who view the Shafer Commission comments as still timely, the NIDA programs are generally praised and defended by drug abuse professionals, whose major complaint is that they should be funded at higher levels.

The extent to which the programs are accomplishing their basic purpose is difficult to judge. Significant treatment evaluations undertaken thus far have produced fairly optimistic conclusions but raise many questions; appropriate methodology for evaluating prevention is even more a matter of debate. Drug user statistics, while undoubtedly more informative than in the past, remain controversial.

In the 1979 State of the Union message, President Carter points to a reduction in the number of heroin addicts as evidence of the success of Federal efforts generally.

> In continuing our efforts to combat drug abuse, my Administration will rely on those programs and initiatives which have proven successful in the past year and which serve as building blocks for future programs. Today, in the United States, there are 110,000 fewer heroin addicts than there were in 1975; 1,000 fewer Americans died of heroin overdoses in the twelve-month period ending June 30, 1978 than in the previous twelve months. ...

The statistics cited were derived from NIDA's Drug Abuse Warning Network (DAWN), and the following editorial, from a recent issue of the U.S. Journal of Drug and Alcohol Dependence (January 1979), is a good example of the disagreements such figures may generate:

HEROIN STATS MISLEADING

> According to NIDA's most recent pronouncements, the number of heroin addicts in the country has dropped 20% since 1975. That is based primarily on data from the Drug Abuse Warning Network (DAWN) and some information on drug price and purity.
>
> It sounds encouraging, just the kind of thing to set our minds at rest and confirm that the trends are going our way.
>
> But to take comfort from the NIDA report is to live in a fool's paradise.
>
> DAWN is not a reliable indicator of the national incidence and prevalence of the use of any drug. It is reasonably accurate only in its reports of hospital emergency room encounters and coroners' reports.
>
> In effect, it tells us about some of the people who had misadventures with certain drugs, many perhaps victims of their own inexperience.
>
> It gives no indication how many people are using a drug, in this case heroin, without running into medical emergency. It does not tell us how many are chipping, using it casually on weekends, and how many young people are being introduced to its use.

> All of these are groups are at high risk for addiction at some point in the future.
>
> We need to know if this pool of non-casualty heroin users is growing. And if so, what happens to the individuals in that pool when the supply mechanisms crank up again?
>
> ...
>
> If we take too much encouragement from NIDA's latest report, we are once again asking for a rude awakening.

On the other hand, it should be pointed out that whatever the nationwide level of drug use is, it might be higher without the availability of such programs as those administered by NIDA.

Treatment

The effect of treatment on drug users is difficult to gauge. All researchers in the field point to the large number of variables involved. The individual's personal history and community background, the age at which treatment commences, the state of the general economy, the conditions in the community to which the patient returns after treatment, the presence or absence of drug-using acquaintances in that community, the presence or absence of stabilizing family or other relationships, the degree of the patient's former dependence on drugs -- these and a number of other factors help determine the direction of a drug user's post-treatment behavior and thus make it difficult to isolate the benefits of the treatment regimen itself.

In a recent review[2/] of major evaluations of NIDA treatment programs, the Congressional Research Service found that the studies which focused on treatment

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2/ Community Treatment Programs of the National Institute on Drug Abuse: Evaluations, 1973-1978. [by] Harry L. Hogan. March 2, 1978. 33 p. (78-123 EPW).

outcome generated guardedly optimistic conclusions. All showed that the populations sampled had reduced drug consumption after a period of treatment. Some of the earlier reports, however, dealt only with patients still under care.

As for criminal behavior, the fact that one early study showed a reduction while the clients were actually under treatment was perhaps to be expected. However, several follow-up studies also showed apparently substantial reductions in arrests and incarcerations. Taking a different approach, another study (Public Research Institute) further supported a positive relationship between availability and use of drug treatment and a decrease in criminal activity.

On the question of the effect of treatment on employment status, the studies reviewed were mixed. Early studies of the Institute of Behavioral Research found gains in this respect to be "slight" and reflective of a failure of the programs to "influence the vast majority of patients in the economic domain." By contrast, the follow-up of one treatment cohort by the same research group saw employment up "appreciably." The latter finding agreed with the results of a MACRO Systems study of the New York City treatment program and a Burt Associates study of the Washington, D.C., program. In New York, 48 percent of the follow-up group had paid jobs at the time of interview as opposed to 33 percent prior to treatment. In the District, there was a 57 percent employment rate at time of interview as opposed to 21 percent during pre-treatment months.

Despite the generally favorable outcomes of the studies reviewed, most authorities are cautious in their reactions. Moreover, some results of the MACRO and Burt studies raise fundamental questions for policy-makers and administrators. Although both of these showed a "relatively high rate of pro-social behavioral change," it was found that the change took place "virtually

irrespective of the type of treatment initiated and, to a considerable extent, irrespective of whether or not clients remained in treatment for more than brief periods." The latter finding, especially, might be taken to imply that the determining factor is not the treatment itself but rather the presence of motivation in the individual who becomes at all interested in treatment.

The studies reviewed also found (1) that the community programs had failed to provide a "sufficiently wide range of treatments to enable adequate testing of alternative approaches for certain population groups;" (2) that ratios of the benefits of all forms of treatment to their costs were in every case greater than one, over a multi-year period reviewed, and that the adjusted ratio was as high as 12.82 for outpatient drug-free treatment; and (3) that the two most cost-effective treatment modalities for opiate users, in terms of reduced drug use, are detoxification-outpatient and methadone maintenance.

NIDA and other interested parties hope that a new evaluation project sponsored by the agency will provide more definitive answers than those conducted in the past. Known as the Treatment Outcome Prospective Study (TOPS), the project is being carried out under contract by the Research Triangle Institute in Chapel Hill, North Carolina. Long-range follow-up will be emphasized.

Finally, a General Accounting Office report on NIDA's treatment programs is now being written. Testifying on March 2, 1979, before the Senate Subcommittee on Alcoholism and Drug Abuse, a GAO official[3/] provided a brief summary of

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3/ Gregory J. Ahart, Director, Human Resources Division.

tentative findings. Pointing out that NIDA had been aware of many of the problems addressed by the GAO investigation and that the agency had initiated corrective actions, he mentioned the following as matters for continuing concern:

--NIDA's method of funding drug abuse treatment programs contributes to problems such as (1) unused capacity in treatment programs, (2) inflation of reported treatment utilization rates, (3) low levels of treatment provided to some abusers, and (4) funding levels that do not reflect actual costs of treatment.

--NIDA's standards for controlling the design and operation of treatment programs should be clarified and upgraded.

--NIDA's plans for States to establish standards that are equivalent to or more stringent than the Federal funding criteria have moved very slowly.

Worth especial note was the finding that the reported rate of clients completing treatment is about 20 percent. The GAO investigators speculate as to whether "the low level of treatment provided to the abusers may well be one of the causal factors of the low success rate."

Research

In 1976, the President's Biomedical Research Panel issued its detailed review and assessment of the conduct, support, policies, and management of biomedical and behavioral research by the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). The Panel

made a large number of recommendations but stressed that the United States "can take pride in a remarkably productive biomedical and behavioral research effort" and noted that 160 of "the most distinguished scientists in the U.S." had reported that the successes of the last three decades "portend an acceleration in the pace of discovery in the immediate and the distant future."

Among the Panel's more specific recommendations applying to ADAMHA were the following:

> Budget items of the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism identified for research must grow sufficiently to support an augmented research effort.
>
> Each institute of the NIH and the ADAMHA should organize a formal structure for knowledge application and dissemination activities.
>
> An Alcohol, Drug Abuse, and Mental Health Administration Advisory Board should be established to advise the Administrator, ADAMHA.
>
> The National Advisory Councils of the NIH and the ADAMHA should be brought to full strength with members appointed solely on the basis of their qualifications and commitment to excellence.
>
> The peer review system must be maintained and strengthened in both the NIH and the ADAMHA.
>
> The initial review for scientific merit of applications for all grants reviewed within an Institute, including program-project, center, and other large grants, should be managed by a separate unit that is totally independent of the units that administer grants.
>
> The Review Committees of the ADAMHA should be brought together to form a central, program-independent "division of research grants" within the ADAMHA.

In most instances, these and other Panel recommendations appear to have been implemented by NIDA. With respect to knowledge application and dissemination activities, the Institute has sponsored the Research Analysis and Utilization System (RAUS), produced and distributed research monographs (mailing list of approximately 4,000), and contracted for production of compilations of abstracts connected with major research issues. A number of internal, inter-agency groups (Scientific Research Advisory Groups) have been formed to advise the ADAMHA Administrator in specific areas, such as treatment research, epidemiology research, etc. Although there are presently vacancies, for the most part the National Advisory Council on Drug Abuse has been at full strength since its establishment. Initial review inception has been removed from the grant management unit; initial review itself, by the outside reviewers, is now conducted, not at the ADAMHA level as recommended, but at the level of the Institute Director's office.

Management Integrity

During January 1978, syndicated columnist Jack Anderson wrote a series of articles alleging improper conduct by the staff, management, grantees, and contractors of NIDA. The allegations fell into three general categories: (1) that there had been a pattern of improper relationships between NIDA staff and the recipients of NIDA funds; (2) that NIDA had funded a series of projects of questionable value; and (3) that senior NIDA staff members had traveled extensively to "exotic locales."[4/] In consequence of the charges, HEW Secretary Joseph Califano requested an audit by the department's Inspector General.

The Inspector General's audit team summarized the conclusions of its investigation as follows:

4/ Memorandum from the Inspector General to Secretary Califano; May 26, 1978; p.1.

> The Anderson allegations are, in large measure, based on fact. It does not follow, however, that actionable improprieties were committed. With the few exceptions noted, our review has disclosed a substantial appearance of impropriety but no provable violations of law.

The principal area in which the Inspector General found questionable procedures was the process of contract award:

> It is crucial that NIDA implement a competitive procurement system in which no single individual can unduly influence an award. The system used by NIDA to award research grants appears to meet this requirement, but the contract award process does not. The NIDA division that sponsors the procurement selects the review committee and usually has at least two members on it. It is theoretically possible, therefore, that a Division Director could influence the committee's selection. 5/

The Oversight Subcommittee held hearings on the Anderson allegations during the last session and plans to continue its investigations of NIDA activities during the current Congress.

5/ Ibid., p. 18.

B. Executive Office of the President

I. Program Description

In June of 1971, former President Richard Nixon issued an Executive order establishing a new agency in the Executive Office of the President (EOP). Designated the Special Action Office for Drug Abuse Prevention (SAODAP), its purpose was to provide White House-level coordination and direction of all activities of the Federal government aimed at the prevention or control of drug abuse, except for those having to do with enforcement of the dangerous drug regulatory scheme or the curtailment of illegal international traffic. Later given statutory basis and funding authority by the Drug Abuse Office and Treatment Act of 1972 (DAOT Act), SAODAP was originally conceived as a temporary entity to provide leadership during an emergency period; the Presidential message to Congress requesting the formal legislation described the step as "an emergency response to a national problem." As the 1972 law was written, SAODAP was scheduled to go out of existence at the end of a three-year period unless the President were to find its continuation necessary. The same legislation established, as of January 1, 1974, a new agency in the Public Health Service, the National Institute on Drug Abuse (NIDA), essentially an elevation of the Old Division on Narcotics and Drug Abuse in the National Institute on Mental Health. Upon expiration of SAODAP, the statute contemplated that the agency's role would be assumed by NIDA.

One of SAODAP's most important tools for achieving its coordinating and policy-guiding goals was budget review. All agencies involved in drug abuse efforts of a non-law enforcement character were obliged to submit their annual and supplementary requests to SAODAP, which then had the opportunity to make changes before sending them on to the Office of Management and Budget.

In the 1976 amendments to the DAOT Act, over administration opposition, Congress provided for creation of a replacement for SAODAP, the Office of Drug Abuse Policy (ODAP), also in the EOP. Charged with making recommendations to the President regarding priorities, goals, and policies for Federal drug abuse programs and to coordinate all Federal drug abuse activities, ODAP was given a three-year authorization. However, the Ford Administration declined to implement the legislation, maintaining that a White House-level agency was no longer needed and that interagency committee mechanisms were more appropriate.

President Carter reversed the Ford Administration decision and established ODAP, a director taking office in June 1977. However, an Executive Office of the President reorganization plan submitted in July 1977 called for the agency's abolition. Since the plan was not disapproved by Congress, ODAP was disbanded as of April 1978. In its place, a small unit of the Domestic Policy Staff, the Drug Policy Office, has been charged with similar functions.

II. Program Data, ODAP -- FY 1978

(a) Personnel and Related Costs . . . . . $ 781,000
Resources to fund ten (10) permanent positions are requested for the Office in FY 1978. Additionally, resources are required for private expertise on an as needed basis for travel, and for other related costs to fulfil the mandate of the Office.

(b) Operations and Facilities . . . . . $ 204,000
To continue the Office of Drug Abuse Policy and sustain its operation for Fiscal Year 1978, a total of $204,000 is required. This amount includes such items as rent, communications, printing, reproduction, office furniture, equipment and supplies. These items are necessary to support the Congressionally mandated requirements such as the development and distribution of an annual drug abuse strategy, as well as initial procurement and maintenance of space, equipment, supplies and services to support the full-time staff and other government and non-government experts.

(c) Contractual and Other Services . . . . . $ 335,000
In addition to continuing the initiatives begun in Fiscal Year 1977, there are several major areas requiring policy and program evaluation. The areas include such specific projects as: evaluate the elimination of the Department of Defense's mandatory urinalysis program and its relationship to abuse levels in the uniformed services; evaluate the effectiveness of the government's Regulatory and Compliance program at the Federal, State and local levels; and an assessment of the viability of crop substitution and economic development in foreign drug producing regions.

SOURCE: U.S. Congress. House. Committee on Appropriations. Treasury, Postal Service, and General Government Appropriations for Fiscal Year 1978. Hearings...95th Cong., 1st sess. p. 381. (Part 3: Executive Office of the President)

III. Budget History

AUTHORIZATIONS/APPROPRIATIONS
(millions of dollars)

FY	Authorizations	Appropriations
SAODAP:		
1975	$82.0	$10.1
ODAP:		
1976	.7 1/	0
1977	2.0	1.1
1978	2.0	1.2
Domestic Policy Staff, Drug Policy Office:		
1979	Indef.	.5
1980 (request)	Indef.	.5

1/ TQ authorization was $.5 million.

Source of Appropriations Data: Drug Policy Office, Domestic Policy Staff.

Emergency Medical Services Systems Act

I. Program Description

The Emergency Medical Services Systems program, authorized in 1973 by P.L. 93-154 and extended in 1976 by P.L. 94-573, is a program of grants and contracts to support the development of a nationwide network of self-supporting regional emergency medical services systems. Grants and contracts are awarded to eligible entities, such as States, local governments, regional consortia, and non-profit organizations, for a succession of three types of activities in the development of emergency medical services systems: (1) the conduct of feasibility studies and planning; (2) establishment and initial operations and (3) expansion and improvement. The program also includes authority for grants for research in the special techniques, methods, and devices, in the delivery of emergency medical services, and also, since the 1976 amendments, authority for a National Burn Injury Program.

II. Program Data

At the completion of FY 1979 program activities, 291 of the 304 designated EMS regions will have received grant assistance under the program. Eighty-five regions will have completed the planning phase and will be ready to move to the operational phase. One hundred and forty regions will be in some phase of operational development. Sixty-six regions will have completed their eligibility under the program and will be moving to self-sufficiency.

Program funds have been awarded to projects in all 50 States and in the District of Columbia, Puerto Rico, Virgin Islands, Guam, Northern Mariana Islands, and the Trust Territory of the Pacific Islands. Almost 50 percent of available funds have been used to serve rural areas.

The research program, under the direction of the National Center for Health Services Research, awarded 20 grants and contracts in 1979.

In 1979, the six Burn Demonstration Centers under the Burn Injury program entered the final phase of the program.

Source: Conversation with Mr. John Reardon, Assistant Director of the Division of Emergency Medical Services, Health Services Administration, Department of Health, Education, and Welfare.

III. Budget History

AUTHORIZATIONS/APPROPRIATIONS
(in millions of dollars)

	FY 1973		FY 1977		FY 1978		FY 1979		FY 1980
	Author.	Approp.	Author.	Approp.	Author.	Approp.	Author.	Approp.	Budget Request
Project Grants									
Sec. 1207	$30	$17	$45	$33.2	$55	$36	$70	$36	$36.6
Research									
Sec. 1207	5	3.3	5	3.9	7.5	3	10	3	3
Training	10	6.6							
Burns									
Sec. 1221			5	3	5	3	5	3	
Total	$45	$26.9	$55	$40.1	$67.5	$42	$85	$442	$39.6

Source: Telephone conversation with Mr. Tom Guanieri, Office of Financial Management, Health Services Administration, Department of Health, Education, and Welfare.

IV. Program Assessment

The original intent of the 1973 Emergency Medical Services Systems Act, P.L. 93-154, was, as stated in H. Rept. 93-149, to respond to the need for:

> "1. Substantially increasing planning and coordination of emergency medical services by local communities, States, and the Federal Government;
> 2. Expanded resources for the establishment, initial operation, expansion and improvement of emergency medical services systems;
> 3. Increased public awareness and understanding of the nature and use of emergency medical services;
> 4. Improved communications facilities for emergency medical services for both the general public and those providing the services;
> 5. Expanded research and training in the nature, techniques, and delivery of emergency medical services;
> 6. Coordination and rationalization of the presently fragmented and duplicative Federal programs for emergency medical services; and
> 7. Removal of existing legal barriers to the effective delivery of emergency medical care." 1/

The legislation was developed as an attempt to deal with certain deficiencies in emergency medical services in this country — unnecessary mortality and disability from medical emergencies; inadequacies in ambulance services in both urban and rural areas, inability of hospital emergency rooms to deal with the increasingly critical situation, and the lack of trained personnel at all levels of emergency medical care.

1/ House Report 93-149, "Emergency Medical Services Act of 1973," report by the Committee on Interstate and Foreign Commerce to accompany H.R. 6485, April 18, 1973: p4.

The program began operation in FY 1974 with the obligation of $17 million for the three types of grants: feasibility studies and planning, establishment and initial operation, and expansion and improvement. Authorization for the program was due to expire at the end of FY 1976. At that time, the General Accounting Office made a study of the program and reported to the Congress on its findings on July 13, 1976. 2/

The GAO, in its report, noted points of progress in improving emergency medical services in the U.S., specifically that communities, with Federal funding, had obtained better equipped ambulances, improved communications capabilities, and up-to-date equipment for hospital emergency departments and other treatment centers. The GAO also found increased awareness among local government and communities of the need for better emergency medical services and of their responsibility to provide such services.

The GAO also cited certain problems in the program. For instance, it found the development of emergency medical systems with strong central management -- one system for several counties -- to be spotty. It found regional management organizations receiving grants to be having difficulty finding permanent financing for administrative and operating costs to replace Federal grants funds. With little control over the financial support made available by local governments and other providers, such as hospitals, the management organizations could not assure continuation of regional systems services when Federal funding stopped. The GAO also found that regional

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2/ Report to the Congress by the Comptroller General of the United States. "Progress, But Problems In Developing Emergency Medical Services Systems", July 13, 1976.

management organizations were sometimes unable to obtain commitment from local governments and local providers to the regional system concept.

The GAO found deficiencies in certain respects of the Department of Health, Education, and Welfare's management of the program that, in its opinion, adversely affected the development of EMS systems. The GAO recommended that the Health Services Administration could improve its administration of the program by: (1) improving its guidelines for evaluating grantee progress and for assessing the readings of grantees to proceed with system development; (2) increasing grant monitoring and technical assistance; and (3) improving coordination with other Federal agencies whose programs relate to EMS.

The GAO included in its report proposed legislative changes in the EMS Act to deal with some of the afore-mentioned problems. These recommendations were to: (1) require local commitment to regional system development; (2) reduce the scope of mandatory system components; (3) improve HEW program administration; and (4) improve coordination among Federal programs related to EMS.

The 1976 EMS Amendments, P.L. 94-573, contained several provisions designed to meet some of the GAO recommendations. It required grantees to provide assurances of support for and participation in the program by public, private, and volunteer organizations and other entities involved in and essential to the effective provision of emergency medical services in the region. Also, grantees would have to show support and cooperation from local legislative and executive governmental bodies and show guarantees of local government financial support for the program after the last year of Federal government support.

Another provision was designed to improve HEW administration by expanding the specificity of assigned administrative duties. The 1976 law also required

the existing Interagency Committee on Emergency Medical Services to develop and publish a plan for coordinated and comprehensive Federal emergency medical services funding and resource-sharing. The plan would also include a description of sources of other Federal support for the purchase of vehicles and communications equipment and for training activities related to emergency medical services.

A provision of the 1976 amendments directed the Division of Emergency Medical Services in HEW to carry out through the Interagency Committee on EMS a study of Federal programs and activities relating to emergency medical services. As a part of that study, the study project team interviewed a number of Federal program officials or State EMS coordinators for their perceptions of the strengths and weaknesses of the Federal program. The following points received strong agreement from those interviewed during 1977 and 1978 (as reported in a draft report from the Health Services Administration):

(1) Federal and State officials consider Federal funding of EMS activities to be inadequate.

(2) State EMS coordinators expressed concern with technical assistance from Division of Emergency Medical Services personnel, calling it less than adequate, crisis-oriented, and dependent on personal relationships with Federal officials.

(3) Some State EMS coordinators expressed criticisms about Division of EMS application procedures, specifically arbitrary criteria in some regards and unattainable criteria in others, unclear instructions, requirements for excessive numbers of application copies, and extensive and repetitious application procedures. 3/

3/ Draft of Annual Report for FY 1977 and FY 1978, "Roles, Resources and Responsibilities of Federal Programs and Activities Relating to Emergency Medical Services." Health Services Administration, Public Health Service, U.S. Department of Health, Education and Welfare. pp. 10-13.

The EMS program has had a number of significant accomplishments in the form of decreases in certain types of deaths and improvements in recovery rates from certain disease and injury conditions, as reported by the Division of EMS, primarily during appropriation hearings.

For instance, during hearings on the DHEW FY 1979 appropriations bill, the division cited:

50 percent decrease in vehicular deaths in seven of eight downstate Illinois regions;

In projects with pre-hospital cardiac care, in Seattle, San Diego, Chicago, Norfolk, Charlottesville, Toledo, Boise, and Kansas City, an initial decrease of 25 percent in cardiac deaths with 80 percent long-term survivors (longer than one-year). 4/

Other accomplishments had been cited during FY 1978 appropriations hearings.

In Massachusetts, a decrease of over 50 percnt in number of deaths en-route by ambulance to hospital;

Examples of regionalization and community support are also cited:

The Norfolk region, involving 10 counties and cities has established a fully operational basic EMS communications system with mobile radios and and hospitals.

4/ Departments of Labor, and Health, Education, and Welfare Appropriations for 1979, hearings before a subcommittee of the Committee on Appropriations, House of Representatives, 95th Congress, 2nd Session, Part 4, p. 87)

The citizens of Lucas County in Northwest Ohio have passed .8 mill levy to establish an advanced life support County EMS system composed of nine life squad units supported by volunteer and paid rescue units and commercial ambulance companies.

The Amarillo, Texas, region has completed a Communications Center in a 25 county rural region, connecting hospitals, ambulances, and regions. 5/

5/ Departments of Labor and Health, Education, and Welfare Appropriations for 1978, Hearings before a Subcommittee of the Committee on Appropriation, House of Representatives, 95th Congress, First session, p. 160).

Health Information and Health Promotion

I. Program Description

The National Consumer Health Information and Health Promotion Act of 1976, P.L. 94-317, authorized a program whose principal activities are: (1) participation in policy development, oversight and coordination of Public Health Service and Departmental activities in disease prevention and health promotion, (2) identification of unmet needs and development of resources to meet such needs, (3) recommendation of necessary changes in current Federal policies with respect to governmental and non-governmental programs, (4) development of a National Health Promotion program, and (5) dissemination of health information to the public through the operation of a National Health Information Clearinghouse. The authorizing legislation, besides creating the general authority in this area, also authorized research programs, community programs, and information programs in health information and health promotion.

II. Program Data

The Health Information and Health Promotion program is not viewed by the Department as a grant or contract program: rather as a central office to encourage others in the PHS and the rest of the Department and in the public and private sectors to fund more prevention, preventive health services, health promotion, and health education and information activities.

In the coming year, the Department expects the National Health Information Clearinghouse to become fully operational. Also anticipated is the release of the Surgeon General's Report on Prevention.

Source: Department of Health, Education, and Welfare. FY 1980 Justification of Appropriation Estimates for Committee on Appropriations.

III. Budget History

AUTHORIZATIONS/APPROPRIATIONS
(in millions of dollars)

	FY 1977 Author./Approp.		FY 1978 Author./Approp.		FY 1979 Author./Approp.		FY 1980 Budget Request
Program Activities Sec. 1701	$7	-	$10	$1.5	$14	$1.4	$5

Sources: 1. Telephone conversation with Ms. Martha Petkas, Office of Disease Prevention, Department of Health, Education, and Welfare.
2. Department of Health, Education, and Welfare. FY 1979 and FY 1980 Justification of Appropriation Estimates for Committee on Appropriations.

IV. Program Assessment

Title I of P.L. 94-317, the National Consumer Health Information and Health Promotion Act of 1976, requires the Secretary of Health, Education, and Welfare to: (1) Develop national goals and strategies concerning health information and promotion, preventive health services, and education in the appropriate use of health care ... (2) Analyze necessary and available resources for implementing the goals and recommend educational and quality assurance policies for needed manpower resources identified by this analysis ... (3) Undertake and support necessary activities and programs to: Incorporate appropriate health education components into our society, especially into all aspects of education and health care ... increase use of health knowledge, skills, and practices by the general population ... establish systematic exploration, development, demonstration and evaluation of innovative health promotion concepts...

(4) Conduct and support research and demonstration concerning health information and promotion, preventive health services, and education in the appropriate use of health care ... (5) Undertake and support appropriate training in the operation of programs concerned with health information and promotion, etc. ... (6) Undertake and support effective and efficient programs of health information and promotion, etc. ... (7) Foster information exchange and cooperation in conducting research, demonstration and training programs respecting health information and promotion, etc. ...

(8) Provide technical assistance for such programs ... (9) Use other available authorities for programs concerned with health information and promotion,

preventive health services, and education in the appropriate use of health care.

The Act also authorized the Secretary to carry out research programs, community programs, and information programs in the area.

During hearings on the FY 1978 HEW appropriations bill, the Department of HEW in responding to submitted questions indicated that it had established an Office of Health Information and Health Promotion which was primarily engaged in formation of plans for implementing the Act.

The Department stated that it did not envision the new office conducting a major grant or contract program, but rather encouraging others in the Public Health Service, the Department, and the public and private sectors to fund more prevention, preventive health services, health promotion, and health education and information activities. The Office, according to this testimony, expected to develop initial goals and strategies in the areas of: childhood immunization, selected aspects of nutrition (e.g., obesity, salt intake), school health, new directions in smoking prevention and cessation, and impact of the media on health. 1/

In Senate hearings on the FY 1979 HEW Appropriations bill, the Department responded to submitted questions concerning the work of the Office of Health Information and Health Promotion. It said that efforts were begun in FY 1977 to identify effective programs to prevent and control disease, to encourage more appropriate use of the health care system and to promote wellness.

1/ Departments of Labor and Health, Education, and Welfare Appropriations for 1978, Hearings before a Subcommittee of the Committee on Appropriations, House of Representatives, 95th Congress, first session, pp. 745-746.

The Office was said to be reviewing several important areas of research on behavior change to try to identify common threads which may exist which cut across several areas of prevention and health promotion. This effort was undertaken because existing efforts to change bad health habits in such areas as smoking, obesity, and physical inactivity, rarely show much success for more than a year. 2/

The Office of Health Information and Health Promotion will become fully operational during FY 1980, so it is still early to assess the effectiveness of the program in implementing the legislative goals of the legislation.

2/ Departments of Labor and Health, Education, and Welfare and related agencies appropriations, FY 1979, Hearings before the Senate Committee on Appropriations, pp. 947-948.

Nurse Training

I. Program Description

Since the 1930's, the Federal Government has been involved in assisting nursing programs. The first comprehensive Federal legislation to provide funds for nursing education, the Nurse Training Act of 1964, consolidated and expanded those programs which had been underway for 30 years. Currently, Federal funds are provided to nursing schools for the construction of teaching facilities, capitation assistance to aid education programs, and financial distress grants to help schools maintain programs or meet special needs. Special projects to improve nurse training are also funded. In addition, Federal funds also authorize grants to nursing schools for advanced nurse training programs and nurse practitioner programs. Student assistance is also available in the form of loans, scholarships, and advanced nurse traineeships.

II. Program Data

A. Construction

Since 1975, there has been a general moratorium on new construction awards with the exception of a single award of $3,500,000 in FY 1978 to assist in the construction of an intercollegiate nursing education center at Spokane, Washington.

B. Capitation Assistance

1. Type of Educational Program	Number of Schools Assisted
1976	1,012 1/
Diploma	176
Associate Degree	505
Baccalaureate	331
1977	1,055 2/
Diploma	168
Associate Degree	522
Baccalaureate	365
1978	1,100
Diploma	190
Associate Degree	550
Baccalaureate	360

1/ Two awards cancelled
2/ Four awards cancelled

2. Effect on enrollment -- From 1964 to 1970, prior to the inception of the capitation grant program, nursing school enrollment increased by less than 18,000 students. From 1970 to 1976, the increase in enrollment has nearly doubled to 34,000 students.

C. Special Projects

FY 1976	211 projects funded
FY 1977	171 projects funded
FY 1978	150 projects funded

D. Advanced Nurse Training

FY 1976	18 projects funded
FY 1977	63 projects funded
FY 1978	96 projects funded

E. Nurse Practitioner Training

FY 1976	17 projects funded
FY 1977	57 projects funded
FY 1978	83 projects funded

F. Advanced Traineeships

FY 1976	109 schools received funds to distribute to students.
FY 1977	135 schools received funds to distribute to students.
FY 1978	109 schools received funds to distribute to students.

G. Scholarships

	Number of Participating Schools	Number of Students Assisted (est.)
FY 1976	1,252	6,000
FY 1977	1,296	6,000
1977-1978 1/	1,350	9,000

1/ Academic Year

H. Student Loans

	Number of Participating Schools	Number of Students Assisted (est.)
FY 1976	1,190	26,250
1976-1977 1/	1,193	28,096
1977-1978 1/	1,205	28,125

1/ Academic Year

Sources:
1. H. Rept. 95-1189, "Nurse Training Amendments of 1978", Report of the Committee on Interstate and Foreign Commerce.
2. Telephone conversation with Mr. Groner, Bureau of Health Manpower, Department of Health, Education, and Welfare.
3. House Committee on Appropriations, Hearings -- Departments of Labor and Health, Education, and Welfare Appropriations for FY 1979.

III. Budget History

AUTHORIZATIONS/APPROPRIATIONS
(in millions of dollars)

Nursing	FY 1965 Author./Approp.		FY 1970 Author./Approp.		FY 1975 Author./Approp.		FY 1977 Author./Approp.		FY 1978 Author. /Approp.		FY 1979[1] Author./Approp.		Revised President's Budget	FY 1980 Budget Request
Construction Sec. 801	2/	-	$25	$8	$45	$19	$20	-	$20	$3.5	-	-	-	-
Institutional (formula) grants (payment to diploma schools 1965-1969)	4	4	35[3]	-										
Capitation Assistance Sec. 810					88	34	55	40	55	30	-	30	-	-
Start-up Assistance					12	-								
Financial Distress Sec. 815					5	4.7	5	-	5	-	-	-	-	
Institutional grants-project grants for improvement of nurse training	2	2	35[3]	8.4[4]										
Special projects Sec. 820					35	19	15	15	15	15	-	15	7.5	1.7

II. Budget History
(Cont'd)

Nursing	FY 1965 Author./Approp.		FY 1970 Author./Approp.		FY 1975 Author./Approp.		FY 1977 Author./Approp.		FY 1978 Author./Approp.		FY 1979 Author./Approp.		Revised President's Budget	FY 1980 Budget Request
Advanced Nurse Training Sec. 821							$20	$9	$25	$12	-	$12	$1.6	-
Nurse Practitioner Training Sec. 822							20	9	25	13	-	13	13	13
Advanced Traineeships Sec. 830	5/	7.3	15	10.4	24	13	20	13	25	13	-	13	-	-
Scholarships Sec. 845	-	-	32 6/	7.1	59	6	SSAN	6.5	SSAN	9	-	9	-	-
Loans Sec. 835	3.1	3.1	20	16.6	35	22.8 8/	30	22.5	35	22	-	22.5	13.5	-
Loan Repayment Sec. 856					SSAN	1.6	SSAN	3	SSAN	1.5	-	1.5	.7	-
Total	$9.1 9/	$16.4	$162	$50.5	$303	$120.1	$185	$118	$205	$119.5	-	$116	$36.3	$14.7

1/ Funds for nurse training were appropriated under a continuing resolution for FY 1979 after the President vetoed the re-authorizing legislation passed by the 95th Congress. However, in presenting his FY 1980 budget, the President also requested some recissions in nurse training funds for FY 1979. Legislation (H.R. 2439) which would make such recissions has already been acted on in the House. The House did not go along with all the President's recision requests but did vote to rescind $17,000,000 in nurse training funds for FY 1979. The Senate voted to rescind $15,750,000 in nurse funds for FY 1979.
2/ Under Health Professions Education Assistance.
3/ $35,000,000 authorized for both formula and project grants with stipulation that $15,000,000 of funds appropriated shall be available for project grants.
4/ Reserved $1,400,000
5/ Indefinite
6/ Amounts authorized by formula if full funding were available.
7/ Reserved $6,750,000
8/ Appropriated -- all other nurse training items funded under continuing resolution for FY 1975.
9/ Includes indefinite funding under Advanced Traineeships.

Sources: 1. H. Rept. 92-259, "Nurse Training Act of 1971", Report of the Committee on Interstate and Foreign Commerce.
2. Telephone conversation with Ms. Terri Ehrenfeld, Office of Financial Management, Health Resources Administration, Department of Health, Education, and Welfare.
3. Department of Health, Education, and Welfare. FY 1980 Justification of Appropriation Estimates for Committee on Appropriations.

IV. Program Assessment

The Nurse Training Act of 1964, P.L. 88-151, established the first comprehensive program of Federal support for nursing education. The legislation consolidated and expanded nearly three decades of Federal support for nurse training progams. Enactment of the legislation represented Congressional response to the increasing concern over existing and potential shortages in the nursing profession.

The 1964 legislation authorized a balanced program of Federal assistance to students and schools of professional nursing including grants for the construction of nursing education facilities contingent upon expansion of enrollment; special project grants to improve nurse training; formula grants to diploma schools which agreed to increase enrollment; low interest, partially cancellable loans for students and traineeships. New program authorities were added in 1966, 1968, and 1971. They included contracts to encourage the recruitment of individuals from disadvantaged backgrounds, capitation grants to schools agreeing to increase enrollments, financial distress grants, and start-up grants. Legislation in 1975 further extended the program. Currently, Federal support of nursing education programs exists in the form of institutional assistance such as capitation, construction, financial distress special projects, advanced nurse training, and nurse practitioner grants as well as student assistance such as traineeships, loans, and scholarships.

Congressional support for nurse training programs has remained relatively high over the years. This is exemplified by Congress' steady refusal, despite administration demands, to drastically reduce program support. It has been the contention of several administration's that a nursing shortage

no longer exists in this country, eliminating the need for so much Federal support. The most recent administration attempts to reduce Federal nursing support include President Carter's pocket-veto of the 1978 nurse training reauthorizing legislation as well as his efforts to drastically cut the FY 1979 and 1980 nurse training program budgets. In its report on the 1978 legislation, the Senate Human Resources Committee cited their belief that the administration's conclusions with respect to funding were "premature and unsubstantiated by available data". Congress has called for a study to determine the need to continue a specific program of Federal financial support for nursing education. In the meantime, many members of Congress have expressed concern that nursing shortages continue to exist within various parts of the country. They fear an abrupt termination of the program might seriously affect the quality of nurse training programs as well as the opportunity for disadvantaged individuals to enter the nursing field. Such concern has led to the re-introduction of nurse training legislation in the 96th Congress as well as Congressional refusal to agree to all of the President's budget cuts.

One of the best indicators of the effectiveness of the nurse training program has been the steadily increasing number of nurses. Since 1957, the number of active nurses has more than doubled to over one million. Eleven years ago, in 1968, there were 300 active nurses per 100,000 population in the U.S. By the beginning of 1977, this ratio had risen to 395 per 100,000 population. Such increases can be directly attributable to Federal aid. Capitation assistance, for example, has been a successful tool to increase enrollment. According to the House Interstate and Foreign Commerce Committee

report on the 1978 legislation, from 1964 to 1970, prior to the inception of that grant program, nursing school enrollment increased by less than 18,000 students, from 1970 to 1976, the increase in enrollment nearly doubled to 34,000.

The House Interstate and Foreign Commerce Committee further cited the impact capitation assistance had made on the national health goals of primary care, manpower production and distribution, and manpower quality and competency. The committee noted that 23 of the collegiate nursing schools had chosen to operate programs for nurse practitioner training in such primary care fields as pediatrics, geriatrics, family health, nurse midwifery, community health and emergency care. The committee added that almost 200 schools planned programs of remote site training; 161 schools provided continuing education courses in which approximately 40,000 professional nurses participated, and more than 150 schools submitted plans to enroll and retain students from disadvantaged backgrounds.

Construction assistance has also influenced the quality of education and expanded nursing enrollment. A total of 225 awards were made to 219 schools for construction of education facilities between December 1965 and June 1974. Such support provided for more than 11,000 new first year places in nursing schools as well as the maintenance of approximately 34,000 student places. Since 1975, there has been a general moratorium on new construction awards with one exception. A single award was made in FY 1978 to assist in the construction of an intercollegiate nursing education center.

Special projects assistance was labeled "the most significant of all nurse training provisions in terms of effectiveness in improving nursing

education nationwide" by the Senate Labor and Public Welfare Committee report on 1975 nurse training legislation. Over the past several years, special projects have usually averaged over 150 awards per year.

Progress has also been made in the area of advanced training for nurses including nurse practitioners. Between 1971 and 1974, over 600 nurses completed preparation to become nurse practitioners. Currently almost 50 percent of the 198 nurse practitioner training programs are supported under Federal authority. Approximately 1,000 practitioners currently graduate annually from these programs; almost 50 percent of them are employed in ambulatory care settings in inner cities and rural areas. In the past three years, advanced nurse training awards have assisted a variety of special educational programs with the enrollments totalling 2000 students.

Student assistance has also made an impact on increasing the supply of nurses in the country. More than 70,000 nurses received traineeships for long-term full-time study and/or short-term intensive courses between 1956 and 1974. In the past several years, over 109 schools have received funds to distribute to students each year. Schools participating in the loan program rose from 426 in 1975 to 1,151 in 1974. In the 1977-1978 school year, the number of schools participating in the program rose to 1,205. Approximately 28,125 students were aided that year by the program. Schools participating in the scholarship program increased from 667 in 1970 to 1,227 in 1974. In the 1977-1978 school year, 1,350 schools participated in the program. Approximately 9,000 students received scholarship assistance that year.

A 1978 Congressional Budget Office report also indicated the achievements made in the field of nursing due to Federal support. For example, CBO

noted that annual additions to the aggregate RN supply are higher than ever. CBO also claimed that the quality of nursing schools had improved as evidenced by the increase in the national accreditation of nursing schools. In 1964, the following percentage of schools were accredited: diploma-67 percent, associate-5 percent, baccalaureate-70 percent. Those figures increased to 90, 40 and 80 percent respectively in 1977. In addition, CBO cited the increase in nurse practitioner supply and the number of graduate degree trained nurses.

While citing these demonstrable gains in the nurse training program over the years, CBO also determined that several problems remain. For example, while the existing aggregate supply is apparently adequate, CBO claimed that the problem of geographic maldistribution still exists. In additon, CBO cited the uncertainty of an adequate supply of graduate degree nurses. Further, while minority enrollment in nursing schools expanded rapidly between 1965 and 1972, CBO noted that recent data indicate such enrollment has stabilized.

In their 1975 and 1978 reports on nurse training legislation, the Interstate and Foreign Commerce Committee also noted the serious geographic maldistribution of nurses. To underline that concern, the committee, in 1978, proposed limiting loan cancellation opportunity for all education loans obtained after the date of its enactment to the shortage area program.

Sources: 1. H. Rept. 95-1189, "Nurse Training Amendments of 1978", Report of the Committee on Interstate and Foreign Commerce, May 1978.

2. S. Rept. 95-859, "Nurse Training Amendments of 1978", Report of the Committee on Human Resources, May 1978.

3. Congressional Budget Office, Nursing Education and Training: Alternative Federal Approaches", May 1978.

4. H. Rept. 94-143, "Nurse Training Act of 1975", Report of the Committee on Interstate and Foreign Commerce, April 1975.

5. S. Rept. 94-29, "Nurse Training and Health Revenue Sharing and Health Services Act of 1975", Report of Committee on the Labor and Public Welfare, March 1975.

Alcoholism

I. Program Description

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, P.L. 91-616, authorized formula and project grants to support alcoholism prevention, treatment and rehabilitation services in local communities. The 1970 legislation also created the National Institute on Alcohol Abuse and Alcoholism. NIAAA develops and supports programs to (1) improve treatment services for alcoholic persons in States and communities; (2) treat and rehabilitate employees with drinking problems in Government and private industry; (3) modify public attitudes toward alcohol and alcohol-related problems by developing a program of education and public information; (4) train professional and non-professional personnel; and (5) determine through research the causes and prevention of alcoholism and alcohol abuse. Since 1970, additional legislation has broadened the Federal alcoholism program. For example, the most recent amendments, P.L. 94-371, placed special emphasis on treatment for underserved populations, women and youth, and mandated a new interest on research.

II. Program Data

A. Grants and Contracts

	1977	1978	1979 est.
Research			
Grants	139	171	158
Contracts	40	9	9
Training			
Grants	92	89	95
Contracts	—	3	6
Community Programs			
Prevention			
Grants	22	32	22
Contracts	1	4	2
Treatment			
Grants	486	516	433
Contracts	4	10	9
State Volunteer Resource Development			
Grants	--	30	30
Uniform Act			
Grants	25	29	34
Formula Grants	56	57	57
Other Contracts	22	1	5

B. Estimate of NIAAA Program Beneficiaries

	1979 Estimate
Occupational	16,000
Women	7,000
Youth	2,000
Indian	18,000
Domestic Violence	---
Other Target Populations:	
Staffing	51,000
Poverty	55,000
Cross Population	33,000
Drinking Driver	18,000
Public Inebriate	26,000
Criminal Justice	3,000
Spanish-Speaking	11,000
Black	7,000
Aged	2,000
Non-categorial	2,000
Total	251,000

Sources:
1. Telephone conversation with Ms. Betty Turner, Office of Financial Management, National Institute on Alcohol Abuse and Alcoholism, Department of Health, Education, and Welfare.
2. Telephone conversation with Ms. Rhoda Christenson, Grants Management Branch, NIAAA, DHEW.
3. Department of Health, Education and Welfare, FY 1980 Justification of Appropriation Estimates for Committee on Appropriations.

III. Administration Proposals

In the FY 1980 budget, the President has proposed a $99 million program which would consolidate State formula grants administered by the Alcohol, Drug Abuse, and Mental Health Administration, and grant programs for mental health services administered by the Health Services Administration. Currently, 15 percent of the HSA program of comprehensive health grants to States is allocated to each State's mental health authority. Some State mental health authorities use such funds only for mental health services, but others use them for alcoholism and drug abuse services as well. Under the President's proposal, grant money would not be earmarked for a specific program such as alcoholism. States would be permitted to allocate funds for all three programs as they deem appropriate.

Although not initiated by the Administration, S. 440, a bill to reauthorize the alcoholism program was introduced by Senator Riegle in the 96th Congress. The Senate Human Resources Subcommittee on Alcoholism and Drug Abuse held hearings on the legislation which would revise and extend the 1970 Act.

IV. Budget History

AUTHORIZATIONS/APPROPRIATIONS
(in millions of dollars)

Alcoholism	FY 1971 Author.	FY 1971 Approp.	FY 1975 Author.	FY 1975 Approp.	FY 1977 Author.	FY 1977 Approp.	FY 1978 Author.	FY 1978 Approp.	FY 1979 Author.	FY 1979 Approp.	FY 1980 Budget Request
Research Secs. 501 and 502	1/	$6.2	1/	$11	$20	$14.8	$24	$16.2	$28	$22.1	$25
Training Sec. 303	1/	1.2	1/	7.8	1/	7.2	1/	7.2	1/	7.2	5.3
Community Programs Project grants and Contracts Sec. 311	-	-	80	51.8	85	73	91	78.7	102.5	78.7	93.3
Formula Grants Sec. 301	40	-	80	52	70	56.8	77	56.8	85	56.8	2/
Special Uniform Grants Sec. 311	-	-	13	2.6	3/		3/		3/		3/
Total	$40	$7.4	$173	$125.2	$175	$151.8	$192	$158.9	$215	$164.9	$123.6

1/ Indefinite
2/ The Administration is requesting that formula grants for alcohol, drug abuse, and mental health be consolidated into one authority. See Section III - Administration Proposals for further details.
3/ Authorization for Uniform Grants combined with authorization for project grants and contracts as of FY 1977.

Sources: 1. Telephone conversation with Ms. Betty Turner, Office of Financial Management, National Institute on Alcohol Abuse and Alcoholism, Department of Health, Education, and Welfare.
2. Department of Health, Education, and Welfare. FY 1980 Justification of Appropriation Estimates for Committee on Appropriations.

V. Program Assessment

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, P.L. 91-616, represented the first major Federal effort to deal with problems associated with alcohol abuse and alcoholism. At that time, Congressional opinion was generally unified that action was needed in this area. For example, the report by the House Interstate and Foreign Commerce Committee reflected concern that "an across-the-board, locally oriented attack on the massive alcohol abuse and alcoholism problem" was needed in the country. On the Senate side, the Labor and Public Welfare Health Subcommittee expressed its view that an effective program could be maintained only with the assistance of "significant financial support" from the Federal government.

The passage of the 1970 Act initiated a major Federal effort in alcoholism research, training, treatment, and prevention. Two components of the legislation were the formula grant and project grant programs. The formula grant program was intended to launch a nationwide effort to alleviate the alcoholism abuse problem by making it possible for each State to stimulate and encourage the establishment of alcohol abuse programs and provide assistance for programs based on the particular needs of a State. Since 1970, every State has established programs under this authority. The second component, project grants were authorized to provide financial assistance to local community programs designed to meet the needs of special target populations. Over the years, these grants have aided the operation of more than 600 community alcoholism programs.

The 1970 legislation also created the National Institute of Alcohol Abuse and Alcoholism. Congress intended NIAAA to be the focal point for Federal activities in the area of alcoholism. Approximately $1 billion has been committed over a seven-year period by the Institute for its alcohol abuse programs. According to February 1979 testimony by Alcohol, Drug Abuse, and Mental Health Administration Director Dr. Gerald L. Klerman before the Senate Human Resources Alcohol and Drug Abuse Subcommittee, such funds have supported a number of achievements. Among other things, Klerman cited his belief that such support has provided a national visibility to alcoholism problems. It has also encouraged State governments to increase their budget allocations for alcoholism programs. Currently, State expenditures for these purposes total four times the NIAAA formula grant appropriation. In addition, NIAAA research capacity has been increased. For example, in FY 1979, significant findings were made in the area of fetal alcoholism syndrome. Advancements were also made in identifying the role of inheritable factors in the transmission of alcoholism. Further, NIAAA efforts have sought to take the "public inebriate" out of the criminal justice system, and provide him or her with the alternatives of treatment and rehabilitation services.

According to Klerman's testimony, the death rate from cirrhosis of the liver, nationwide, has declined over the past three years for the first time in half a century. Furthermore, Klerman maintained total per capita consumption of alcohol has stabilized. In addition, he indicated that public awareness of alcoholism has increased and the stigma of alcoholism was being reduced.

Federal efforts regarding alcohol abuse problems were evaluated by a 1977 General Accounting Office report, "Progress and Problems in Treating Alcohol Abusers". In that report, GAO noted difficulty in determining the overall impact of the Institute's program on alcohol abusers. However, GAO indicated that certain progress had been made including the funding of alcoholism treatment programs which benefited thousands of people. In addition, GAO found that Federal involvement had stimulated greater State and local involvement in alcoholism treatment programs. However, the GAO report also revealed certain problems limiting NIAAA's attack on alcoholism. For example, NIAAA's planning efforts for treatment programs were criticized. GAO also criticized what it termed a slow Federal approach by NIAAA against the alcoholism problem. GAO maintained that NIAAA had been unable to develop a coordination mechanism to insure that all Federal alcohol related activities are integrated into a single coordinated Federal approach to the alcohol abuse problem. Although HEW indicated agreement with the thrust of the GAO recommendations, the department objected to the "passage of time since GAO has collected its information" (three years). During that time, HEW noted that new legislation passed, NIAAA leadership changed, staff increased, and progress on many of the problems has been made.

The House Interstate and Foreign Commerce Committee, in its report on alcoholism legislation in 1976, also noted that progress had been made in the fight against alcoholism. The Committee indicated difficulties in determining whether an actual reduction in the number of alcohol abusers had occurred since it had received no information which would indicate a reduction in alcoholism abuse. In fact, the Committee found existing evidence

showed that the incidence of alcohol abuse had been increasing at an alarming rate for two specific segments of the nation's population -- youth and women. The legislation which was enacted that year, P.L. 94-371, even placed special emphasis on women and youth as well as other underserved populations. In the past, the House Appropriations Committee had also noted this increase. As a result, the Committee issued a directive to NIAAA requesting expansion of outreach and service programs for women. As an indication of progress in this area, NIAAA reported that beginning in FY 1976, their agency began an extensive campaign directed toward providing services to certain target populations including women and youth. In FY 1977, NIAAA complied with a Senate Appropriation Committee directive that the Institute develop a comprehensive public education and information disemination program dealing specifically with teenage alcoholism programs. In FY 1978, the Institute continued to fund alcoholism treatment projects targeted to high risk, poverty and minority populations including women and youth. Approximately 217,000 people were served by such projects during that year.

National Health Planning and Resources Development;
Titles XV and XVI of Public Health Service Act

I. Program Description

The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) provided authority for creation of a nationwide network of State and areawide health planning agencies responsible for developing local and Statewide health plans to be used as the basis for health resources allocation within specified health service areas. The health planning agencies are to ensure that needed services are provided while duplicative services are eliminated and the development of less expensive, equally effective alternatives to inpatient medical care is encouraged.

At the local or areawide level, entities called health systems agencies or HSAs (which are usually private nonprofit corporations) are the basic component in the structure. At the State level, entities referred to as State health planning and development agencies or State agencies (in all cases a unit of State government) compose the next tier in the health planning system. State agencies are in turn advised by Statewide health and coordinating councils or SHCCS, composed of State officials and HSA representatives. At the national level, there is a National Council on Health Planning and Development, set up to advise the Secretary of HEW on implementation of the program.

The Act also authorized the Secretary of HEW to issue national guidelines for health planning, including standards for the appropriate supply, distribution, and organization of health resources. Funds were also made available for contracts to establish regional centers for health planning,

designed to offer technical assistance to the various health planning bodies. Authority was also provided for a program of demonstration grants to be awarded to State agencies for purposes of hospital rate regulation.

In addition, the law authorized a program of Federal assistance for health resources development (title XVI of the Public Health Service Act) through grants, loans, and loan guarantees for construction and modernization of medical facilities, for special projects for the elimination or prevention of safety hazards or to assure compliance with licensure or accreditation standards, and for area health systems development.

II. Program Data

Health planning agencies have been established in 205 geographic regions and 57 States, including eight so-called "section 1536 States" which carry out both the HSA and State agency functions. These planning agencies include 205 health systems agencies (HSAs), 57 State health planning and development agencies (SHPDAs), and 51 Statewide health coordinating councils (SHCCs). In addition, ten centers for health planning and a National Health Planning Information Center, both authorized under the Act, have been established to provide technical assistance and information to the planning agencies.

By the end of 1978, 168 HSAs (80 percent) had achieved full designation status, thus having developed satisfactory health systems plans and annual implementation plans, as well as having demonstrated a capacity to perform all functions required of them under statute. Eight State agencies were fully designated during 1978, each of them having developed a satisfactory certificate of need program which provides for the review of proposals for new construction, replacement, and modernization of health facilities and the elimination of duplicative health services.

The Department of HEW estimates that, by the end of 1979, approximately 191 HSAs and 41 State agencies will be fully designated and will be performing all functions required of them under statute, including the review of new institutional health services, review of the appropriateness of existing health services, and review and approval of the proposed use of certain Federal health funds in their respective areas. In many of the 33 additional State agencies projected to be fully designated in 1979, full

designation is contingent on the enactment of State legislation which will allow the development of acceptable certificate of need programs.

While no funds have been obligated for State allotment grants for construction or modernization of medical facilities (under section 1602 of the statute), grants have been made under section 1625 of the Act to fund projects designed to prevent or eliminate safety hazards and to assure compliance with State or voluntary licensure or accreditation standards. In 1978, $11.4 million was awarded to fund four section 1625 projects from an approved list of 48 potential recipients. The Department estimates that during 1979 approximately 40 of the remaining approved projects will be funded.

Source: Department of Health, Education, and Welfare. FY 1980 Justification of Appropriation Estimates for Committee on Appropriations.

III. Budget History

AUTHORIZATIONS/APPROPRIATIONS
(in millions of dollars)

	FY 1975 Author.	FY 1975 Approp.	FY 1976 Author.	FY 1976 Approp.	FY 1977 Author.	FY 1977 Approp.	FY 1978 Author.	FY 1978 Approp.	FY 1979 Author.	FY 1979 Approp.	FY 1980 Budget Request
Title XV, Health Planning and Development											
Sec. 1516(c)(1) Health Systems Agencies Planning Grants	$60	—	$90	$64.09	$125	$97	$125	$107	$125	$107	$115.4
Sec. 1525(c) State Health Planning and Development Agencies Grants	25	—	30	19	35	24.5	35	29.5	35	29.5	30
Sec. 1526(e) Grants for Rate Regulation	4	—	5	—	6	2	6	2 [1/]	6	2 [1/]	--
Sec. 1533 Technical Assistance	indefin.		indefin.		indefin.		indefin.		indefin.		
Sec. 1534(d) Centers for Health Planning	5	10	8	7.5	10	6.5	10	6.5	10	6.5	—
Total	$94	$10	$133	$90.59	$176	$130	$176	$145	$176	$145	$145.4
Title XVI, Health Resources Development											
Sec. 1602 Formula Grants	$125	—	$130	$51.76 [2/]	$135	--	$135	--	$135	--	--
Sec. 1625 Project Grants	—	--	--	--	--	--	67.5 [3/]	--	67.5 [3/]	—	--
Sec. 1640 Grants for Area Health Services Development Fund	25	—	75	--	120	—	120	—	120	—	--
Total	$150	—	$205	$51.76	$255	--	$322.5	--	$322.5	—	--

1/ Program budget transferred to HCFA.
2/ 22 percent of this amount may be used for section 1625 project grants. Appropriation to remain available for 3 fiscal years. In FY 1978, the Health Planning Bureau received permission from Congress to reprogram the remaining formula grant funds (remaining after the 22 percent for the project grants was subtracted) for use as project grants. Congress also extended the availability of these funds through FY 1979.
3/ P.L. 95-215 (Health Professional Education Amendments of 1977) provided a special sepsrate authorization for section 1625 project grants.

Sources: 1. Information is drawn from H. Rept. 95-1185, "Health Planning and Resources Development Amendments of 1978", Report of the Committee on Interstate and Foreign Commerce.
2. Department of Health Education, and Welfare. Fiscal Year 1980 Justification of Appropriation Estimates for Committee on Appropriations."

IV. Program Assessment

The original intent of P.L. 93-641 was to create throughout the Nation a new, strengthened and improved Federal, State and areawide system of health planning and resources development. The various health planning entities set up under the terms of the Act were directed to address their efforts to increase the accessibility, acceptability, continuity, and quality of health services; restrain increases in the cost of providing health services; preventing unneccessary duplication of health resources; and ultimately to improve the health of the residents of each health service area.

Reflecting concern that earlier health planning efforts had been plagued by a number of interrelated problems, the Committee in its orginal design for P.L. 93-641 sought to embody the following principles:

(1) Planning should be done by organizations which represent and incorporate the interests of consumers of health services, providers of the services, and concerned public and private agencies and organizations.
(2) In order to be effective, health planning must be adequately financed.
(3) Effective planning requires a strong emphasis on the implementation of plans and implementation requires that planning agencies have authority with which to implement the plans.
(4) The generation of new health resources should be closely tied to health planning.
(5) If health planning is to be done, it must be good health planning.
(6) Effective Federal, State and areawide health planning will be possible only if the Federal government itself engages in health planning.

> (7) If health planning is actually to improve people's health, it must not be limited just to planning for medical needs. 1/

The law emphasized an important, indeed dominant role for consumers in formulation of health planning policy and decisions. It detailed an intricate series of interrelationships among Federal, State, and local interests to improve coordination of planning activities and, to the extent possible, to avoid jurisdictional conflicts and fragmentation. It required agencies to formulate concrete health systems plans (HSPs) and annual implementation plans (AIPs) which would act as the basis for decisions regarding which specific projects and programs would be given priority and encouragement within their respective areas. National guidelines were drawn up to provide standardized criteria (adjusted to local needs and circumstances) for determining and evaluating the supply, distribution and organization of health resources.

State agencies were mandated to establish State certificate of need (CON) programs which would review all proposals for new institutional health services proposed to be offered or developed within the State. The CON programs were to contain certain sanctions so that only those services, facilities, and organizations found to be needed would actually be offered or developed in the State. HSAs were expected to participate in the certificate of need review process as well as conduct reviews of the appropriateness of existing health services, priorities for modernization, construction, and

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1/ House Report 93-1382, "National health policy, planning and resources development act of 1974," report by the Committee on Interstate and Foreign Commerce to accompany H.R. 16204, September 26, 1974: pgs. 32-35

conversion of medical facilities, and applications for Federal funds for various health programs within their respective health service areas. State agencies were further required to develop State health plans (SHPs) representing a Statewide composite of needs and priorities addressed in the plans submitted by each State's HSAs.

Since enactment of the program much time has been spent in establishing the various component parts of the health planning network. While concern exists about the overall, long-term effectiveness of the health planning system in accomplishing the basic intent of the law, there is also recognition that the initial development of such a large complex system is a time-consuming, contentious, and often difficult process. Some believe, it may still be too soon to measure the effect of planning entities which in most cases have been fully operative for only slightly more than two years and in many cases are not yet even fully designated in accordance with the terms of the Act and its subsequent regulations.

One of the key measures used to evaluate effectiveness of health planning is the degree to which health planning activities have resulted in documented cost savings for the health care system. A survey released February 1979 by the American Health Planning Association reports that health systems agencies and State health planning and development agencies disapproved $2.3 billion of a proposed $10.6 billion in capital investments between August 1976 and August 1978. The survey covers 166, or 81 percent, of the country's 205 HSAs and 27, or 52 percent, of its 57 SHPDSs.

The report shows that planning agencies have saved money not only through certificate of need review and reviews required under section 1122

of the Social Security Act, but also through technical assistance to health care facilities and the influences of their health systems plans and State health plans. For example, the health planning review process has in some cases acted to discourage institutional providers from submitting proposals known to be inconsistent with the health systems plan of the local HSA. In other cases, unofficial contacts between providers and the HSA may elicit negative responses to part or all of a capital expenditure proposal, resulting in withdrawal or modification of certain proposals prior to official submission.

The report notes that if unofficial data -- referred to as documentable pre-application "reviews" -- are considered, the figure for total cost savings by HSAs and SHPDAs would total $3.4 billion. The report notes that 16,000 hospital beds were unofficially proposed, and 11,500 were requested in official applications. Planning agencies disapproved 3,700 beds officially, and 7,900 beds if unofficial reviews are included. Some 49,000 skilled nursing home or intermediate care facilities were also unofficially disapproved -- 20,000 officially -- out of an unofficially proposed 114,000 beds, or 85,000 officially requested. It was estimated that such capital investment denials will save about $10 billion in operating costs in the 1980s.

While cost savings attributable to effective health planning may be a measurable output, it is perhaps far more difficult to assess the effectiveness of health planning activities in dealing with other key health issues, such as accessibility and quality of health services, improvements in health status, etc. Some have pointed to the actual limitations of health planning to deal with problems generally regarded as outside its control, e.g. the

basic structure and orientation of the medical profession with its emphasis on specialization, hospital as opposed to ambulatory care, high technology, and surgery. In addition there are problems presented by the fundamental nature of the medical marketplace with the capacity of supply to generate demand unchecked by a relatively open reimbursement system.